DATE: [Date]

TO: [Surgeon Name/Medical Facility Name]
ADDRESS: [Street Address]
CITY/STATE: [City, State, Zip Code]

RE: Letter of Protection
PATIENT: [Patient Name]
DATE OF INCIDENT: [Date of Accident/Injury]
CLAIM NUMBER: [Insurance Claim Number, if applicable]

To Whom It May Concern,

Please be advised that this office represents [Patient Name] in a legal claim for personal injuries sustained on the date referenced above. My client requires neurological surgical intervention as a result of these injuries.

This letter shall serve as a Letter of Protection regarding the medical expenses incurred for the neurological surgery and related treatment provided by your facility. We hereby request that you provide the necessary surgical services and agree to withhold immediate collection efforts against the patient.

In exchange for your medical services, we agree to protect your outstanding medical bills and will pay them directly from any settlement, judgment, or recovery obtained on behalf of [Patient Name]. This agreement is a lien against any such proceeds.

Please note that this letter does not guarantee the recovery of any specific amount, but it does guarantee that your bill will be honored from the proceeds of the legal claim before any funds are distributed to the client.

We request that you provide our office with a copy of the surgical reports and the final itemized billing statement once the procedure is completed. Please sign below to acknowledge your acceptance of this Letter of Protection and return a copy to our office.

Sincerely,

[Attorney Signature]
[Attorney Name]
[Law Firm Name]

ACKNOWLEDGMENT AND ACCEPTANCE:

I hereby agree to the terms of this Letter of Protection and agree to look to the proceeds of the legal claim for payment of medical services rendered.

_____
[Authorized Signature for Medical Provider]

DATE: _____